Alberta Health Services

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown	

Facilitated Access to Specialized Treatment (FAST) Adult Neurosurgery & Spine Referral

To confirm fax numbers and other clinic information visit the Provincial Neurosurgery, Adult Referral Pathway, or www.albertareferraldirectory.ca

For evolving Neurologic Deficit **call RAAPID.** For Functional Neurosurgery *(i.e. movement disorder surgery and epilepsy surgery)* refer to Neurology.

If you have not received notification from our program within 5 business days, please call FAST at **1.833.553.3278**

Date *(dd-Mon-yyyy)*	Patient Primary Phone	Patient Secondary Phone	
Patient Address			
Legal Guardian Name *(if applicable)*	Phone	Relationship	
Referring Provider	Phone	Fax	PRAC ID
Clinic Address	Primary Care Provider and Contact Info *(if available)*		

Requested Provider

☐ Next Available Provider **OR** ☐ Specific Provider _____

☐ I have discussed this patient with the named neurosurgeon above *(if specific provider is checked)*

Location Preference ☐ None ☐ Edmonton ☐ Calgary

☐ Second Opinion *(include initial opinion report with referral if available)*

☐ Previously seen by the following Neurosurgeon for the same problem _____

Referral Requirements

Attach referral letter **OR** complete information on **page 2**.
Include results of mandatory investigations as per the Provincial Neurosurgery Referral Pathway:
https://www.albertahealthservices.ca/assets/info/aph/if-aph-prov-neurosurgery-referral-pathway.pdf

Reason for Referral

(choose one)

☐ Carpal Tunnel Syndrome
☐ Median Nerve Entrapment
☐ Radial Nerve Entrapment
☐ Ulnar Nerve Entrapment
☐ Intracranial Neoplasm
☐ Cranial Bone Neoplasm
☐ Hydrocephalus
☐ Cerebrovascular

Other *(specify)*

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(check one)

☐ Referral letter attached **OR** ☐ All relevant information is provided below as per QuRE Checklist